Brian S. Taylor, M.D.
Joyce Weckl, PMHNP
Fernando Cervantes, PMHNP
1000 Town Center Drive, # 400
Oxnard, CA 93036
(805) 654-0926 Fax (805) 654-0949

Insurance Coverage Declaration

I, _____ declare that I:
(Must PRINT patient's full name (First & Last)

_____ do not have active health insurance coverage.

_____ have active coverage with a plan that this office does not accept and/or bill.

I understand that because of this I am considered a CASH patient and that I am receiving a cash discount. I agree that I will pay in full at the time of service for all treatment rendered.

I understand that this office will not submit any claims for services provided on a CASH status basis to any insurance company for consideration.

I also understand that if I submit my receipt to an insurance company for consideration, it will only be for reimbursement of the discounted amount I paid. I understand and agree that any discounts or non-allowed amounts as determined by an insurance company will not be accepted for CASH status discounted services.

My signature on this document declares my understanding and acceptance of the statements listed above and I declare that all information provided is true and correct to the best of my knowledge. I understand that I am required to inform this office of any and all active health insurance policies and agree to do so if my current status changes.

Patient Signature: _____ Date: _____

If patient is a minor:

Printed Name of Legal Guardian: _____

Signature of Legal Guardian: _____ Date: _____